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Kalucy, E.C., Hordacre, A., Howard, S.L., & Moretti, C.M., 2009. Population health role of the Divisions of General Practice Network. Public Health Bulletin South Australia, 6(2), 17-20.

Population health role of the Divisions of General Practice Network

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What are Divisions of General Practice?

Divisions of General Practice provide services and support to general practices to achieve health outcomes for the community within defined catchment areas. Divisions can achieve systemic improvements in local primary care that cannot be achieved by individual general practitioners working alone.[1] Today the Divisions Network, which is funded largely by the Australian Government, consists of 111 Divisions of General Practice (divisions), six state-based organisations (SBOs), two hybrid SBO-divisions (in the Northern Territory and the Australian Capital Territory) and the Australian General Practice Network. With its national coverage, the network has a workforce of more than 3000 staff members with clinical, health science, public health and management skills, adding substantial infrastructure to primary care.[2]

Divisions address the needs of general practitioners (GPs) and practices and the health of their populations, and respond to local and national priorities. Unlike some primary care organisations in the United Kingdom and New Zealand, divisions have no contractual 'hold' over the general practices in their region. Their capacity as change agents depends on the extent to which they can persuade, inform and legitimise their activities.[3]

What is the population health role of divisions?

Since the implementation of the divisions program, the Australian Government has viewed divisions as playing a significant role in population health,[a] implementing and supporting health promotion, disease prevention and treatment programs within identified subpopulation groups.[4] In this context, divisions are expected to:

- improve access to general practice services by considering the characteristics of the local population and the potential mismatch between need, access and use of general practice services
- improve the quality of general practice services through stronger chronic disease and injury prevention activities, better management of chronic disease, earlier diagnosis and intervention.[4]

Whereas GPs might identify their *practice population* as the people who attend the practice, a *division population* includes the entire population of the defined catchment area. In addition, divisions target specific activities toward different subpopulations identified by demography; health problem (or risk); or geographic, political or administrative territory.[5] Because divisions fulfil multiple roles for multiple stakeholders, they sometimes experience tension between their role as a local support organisation for GPs and their role in population health.[5]

Assessing population needs

A population health approach includes assessing the needs of a defined population, then planning, implementing and evaluating the strategies to address these needs. Divisions have a dual role—supporting general practice to obtain and use data about practice populations, and identifying and addressing the needs of the local community within the division population. In Australia information technology and information management (IM–IT) has been identified as an indispensable element in a population health approach at both the general practice and division levels.[6]

Using IM–IT to identify the needs of *practice populations* has become simpler and more systematic due to business management tools such as the Practice Health Atlas[7] and Pen Computer Audit Tool.[8] General practices using these tools, with the support of their divisions and SBOs, are better able to understand the sociodemographic and health characteristics of their patients.

[a] The term 'population health' is used here rather than 'public health', which is associated with health care delivered in the government-funded sector.

Data availability for needs assessment and planning at the *division population* level has been enhanced by the population health profiles prepared for each division in Australia.[b] These profiles[c] demonstrate that individuals using practices within a division do not always reside within the division catchment. For example, in South Australia in 2003–04 between 68% and 94% of people attended general practices in the division in which they resided. The lower figure is seen in urban divisions with a mobile commuting population (e.g. Adelaide Northern and Eastern Division, 68.5%), whereas in the rural Eyre Peninsula Division 94% of GP attendances were of individuals within the division catchment. Divisions are aware of the difference between practice population and division population, incorporating this consideration into planning and implementing their population health role.

Data are complemented by each division's knowledge of the local area acquired through multiple sources, including community input. Divisions engage their local populations in a number of ways such as community education, forums and surveys. In 2006–07, 65% of Australian divisions involved community members in program evaluation, 57% in strategic planning and 48% in needs assessment. Divisions complete the consultation process by providing feedback to consumer and community members, often through websites, community newspapers or division newsletters.[2]

A place at the planning table

In 2006–07 divisions were represented on more than 2000 external committees, indicating strong engagement with communities throughout Australia.[2] Almost all divisions were represented on area, district and regional health service committees, and many sat on committees about specific local issues. This collaborative approach is also reflected in formal reciprocal agreements (or memorandums of understanding) established between divisions and other organisations—almost two-thirds of divisions reported agreements with hospitals and half with mental health services in 2006–07.

Divisions' role in improving access

Limited access to primary health care services is more common in rural and remote areas, where workforce recruitment and retention is a major focus for divisions (and government). Almost 80% of rural and remote divisions are therefore involved in improving access to locum services, compared to around 20% of metropolitan divisions (Figure 1). Taking a different approach, nearly 700 GPs were paid on an hourly or sessional basis to address access barriers such as limited practice hours or financial constraints in 2006–07.[2] For example, these GPs worked in youth health clinics or in-school services, provided health checks or screening

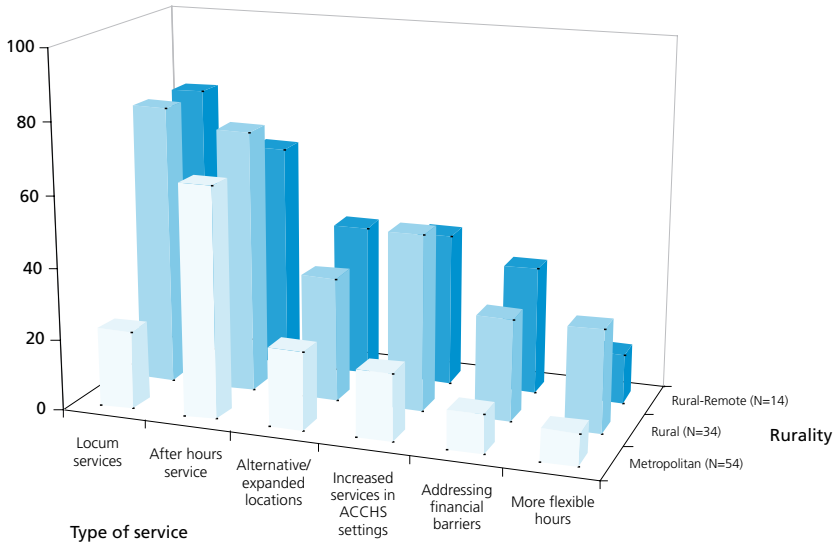

Figure 1: Proportion (%) of divisions providing services to increase access to GP services by rurality, 2006–07
Data source: Annual Survey of Divisions 2006–07.[2] Rurality calculated using Rural, Remote and Metropolitan Areas classification.[9]
ACCHS: Aboriginal Community Controlled Health Service.

[b] Population Health Information Development Unit (PHIDU), University of Adelaide. www.publichealth.gov.au/publications/population-health-profiles-of-the-divisions-of-general-practice.html.

[c] Table 3 of 2007 Supplementary profiles prepared by PHIDU

in hard to reach rural and remote settings, or specified services for Indigenous Australians. To increase access to allied health professionals, divisions directly contract them to deliver services to their communities through federal programs such as More Allied Health Services (MAHS) and Access to Applied Psychological Services (ATAPS).

Divisions' role in health promotion and secondary prevention

Divisions have played a substantial role in furthering prevention activities in primary health care through implementing government policy and initiatives at the state or national level, a task that GPs alone would be ill equipped to do. Divisions tailor their approaches to population health to suit the program and target population through a combination of education, practice support, recall systems, community awareness and collaboration with other providers (Figure 2). As previously identified, divisions are engaged to support both practice populations (i.e. through practice support or recall systems) and the division population or subpopulations within their catchment (as is evident in a community awareness approach). Divisions typically aim to reach a broad population through their prevention programs—most reported no specific target for many of their prevention activities in 2006–07.[2]

Responding to local population health needs

Divisions operate at a local level and are embedded within the communities with which they work. This on-the-ground understanding of their communities and the conditions in which they live makes them ideally placed to respond to disasters, public concerns and ongoing health needs. To respond to disasters, divisions require an emergency plan, and the ability and will to put it into action. For example, in the February 2009 Victorian bushfire devastation, divisions in the affected areas facilitated initial action and recovery, providing information and support services including treatment clinics and counselling. The coordinated response effort shown by these Victorian divisions is a result of having established emergency response plans formulated with other local organisations. Similarly, divisions in other areas of Australia have responded to their local populations' needs. Eight divisions reported responding to the needs of drought-affected communities across Australia from 2005 to 2007.[2,10] Relief activities for local northern Queensland divisions were targeted toward communities affected by Cyclone Larry in 2006; and New South Wales and South Australian divisions provided support to local communities after the 2007 Newcastle floods and the 2005 Eyre Peninsula bushfires, respectively.

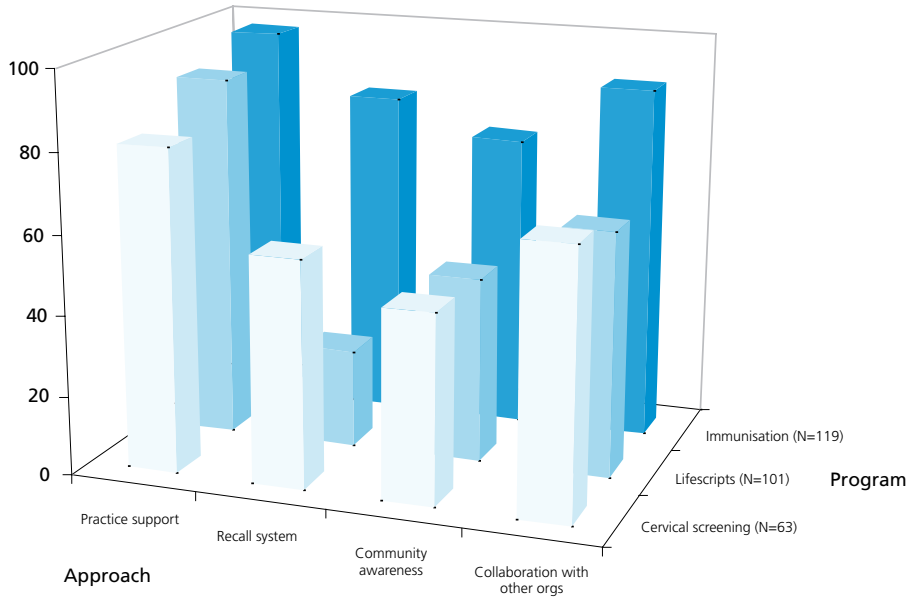

Figure 2: Proportion (%) of divisions conducting prevention programs by approach, 2006–07
Data source: Annual Survey of Divisions 2006–07.[2] The Lifescripts program involves a holistic approach to prevention, incorporating risk factor management specifically in the areas of smoking, alcohol consumption, nutrition and physical activity.

Local need is not always based on critical events, but may address long-term solutions to chronic problems within the community. Many of the South Australian Riverland's GPs and a MAHS-funded Aboriginal health worker provide health care to the local Indigenous population from a bus, locally known as the Peelies Bus, that visits all the major Riverland towns once a fortnight. The Peelies Bus aims to reduce disparities in the health and wellbeing of the Riverland Aboriginal community by improving access to timely and culturally appropriate services, and linking into existing services rather than replacing them. The bus depends on a close working relationship between the three partner agencies (Riverland Division of General Practice Inc., Riverland Regional Health Service Inc. and Families SA). It also benefits from the availability of 'point of care' pathology testing equipment. Results are available on the same day, at the same location, compared to the usual delays associated with waiting for results to return from the laboratory.

Final comments

Divisions are already playing a role in improving population health in their local communities. The potential availability of more reliable practice data through IM–IT development could mean that divisions have a greater impact on health service planning and policy.[2] Division Network staff will need to add data analysis to their existing skills set, and continue to work with their practices to demonstrate the value of a population rather than an individualist focus.[11] Divisions' unique understanding of the population health characteristics within their catchments enables them to engage in focused improvements in the quality of, and access to, primary health care services.

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